each facility continues to have a "favorable" rating until a subsequent survey reports a "non-favorable" rating.

K. Incentives for rates paid on and after July 1, 1991, shall be paid to providers whose annual rates of cost increase for operating costs or resident care costs from one cost reporting period to the next are less than 1.786 times the average cost increase for the applicable period documented by the ICF/MR-DD Cost Inflation Index used in this plan. Calculation of incentives shall be as detailed in Section V.B.7. of this plan.

1. To encourage high-quality care while containing costs, incentive payments shall be paid to those facilities which are not out of compliance with any Condition of Participation. Cost containment operating and resident care incentives shall be prorated for the percentage of days that a provider is out of compliance with any Condition of Participation during the rate semester in effect one year prior to the rate semester being set.

L. A provider's reimbursement for service provided under the Florida Medicaid Program shall be the lower of: the provider's usual and customary charges to the general public for such services, except for public facilities rendering such services free of charge or at a nominal charge, that is, less than or equal to 50 percent of costs; or the rates established for the provider under this reimbursement plan.

M. The use of a target rate of inflation for cost increases shall be used as a measure of efficient operation for purposes of this reimbursement plan. The target rate of inflation principle is that a provider's operating and resident care per diems by reimbursement class should not increase from one fiscal period, that is, year, to the next by a percentage amount which exceeds 1.786 times the average percentage of increase in the Florida ICF/MR-DD Cost Inflation Index for the same period. If a provider's per diem costs for either reimbursement class for operating or resident care exceeds the target rate of inflation, then the allowable per diem costs of the period in which the excessive costs occurred shall be limited to a level equal to the prior period's allowable per diem costs inflated by the target rate percentage. Only

~~allowable per diem costs shall be used for prospective rate setting purposes and for future target rate comparisons.~~

J.~~N.~~ Base Costs:

The initial base costs for each provider ~~which qualifies for rebasing based on Section V.B.9. of this Plan,~~ shall be allowable costs documented by the cost report used to establish the rate being set. For new providers entering the Medicaid program the initial base costs shall be established in accordance with Section IV.I. of this plan. Prospective rates calculated using unadited costs shall be retroactively adjusted when audit results become available.

K.~~O.~~ Aggregate test comparing Medicaid to Medicare according to 42 CFR 447.253~~(c)(2)~~(6) (1993~~7~~), the Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement.

At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare principles, property cost ~~incentives~~ shall be reduced or eliminated as necessary to meet the aggregate test.

V. Methodology

~~A. Prospective rate-setting method for rate semesters, for providers that qualify for rebasing based on Section V.B.9. of this Plan.~~

~~1. Determine which providers qualify for rebasing this rate semester based on Section V.B.9. of this Plan and calculate their prospective rates in 2.-6. below.~~

~~2. Review and adjust each provider's cost report referred to in Section IV. N.above to reflect the results of desk or on-site audits, if available.~~

~~3. Determine total allowable cost by reimbursement class for property cost, resident care cost, operating cost, and return on equity or use allowance if applicable. See the Definitions section of this plan for the definitions of allowable costs for each of the four cost components. Costs shall be allocated~~

~~to each reimbursement class by the methodology shown in Appendix A. Providers with six beds or less shall be allocated to costs for each reimbursement class by the methodology shown in Appendix A-1.~~

~~4. Calculate per diems for each of the four cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.~~

~~5. Adjust the operating cost per diems and resident care cost per diem for Step 3 for inflation by multiplying by the fraction:~~

~~Simple average of the Florida ICF/MR-DD monthly cost inflation indices for the prospective rate period divided by the simple average of the Florida ICF/MR-DD monthly cost inflation indices for the provider's cost report period.~~

~~For rates effective July 1, 1991, the prospective rate semester used in calculating the above fraction shall be the period July 1, 1991 through March 31, 1992. The calculation of the Florida ICF/MR-DD Cost Inflation Index is displayed in Appendix B.~~

~~6. The prospective reimbursement rate for each reimbursement class for the initial rate semester beginning October 1, 1989 shall be the sum of the property and return on equity or use allowance per diems from Step 3 plus the operating cost and resident care cost per diems from Step 4 above.~~

A.~~B.~~ Prospective rate-setting method for rate semesters beginning on or after July 1, 1991~~, for providers that do not qualify for rebasing based on Section V.B.9. of this Plan.~~

1. For rate semesters beginning on April 1 of a given year, the prospective rates shall be set using the most current acceptable cost report on file with AHCA as of February 1 of that year. For rate semesters beginning on October 1 of a given year, the prospective rates will be set using the most current acceptable cost report on file with AHCA as of August 1 of that year. For the rate semester July 1, 1991 through March 31, 1992, the same cost reports used in

setting April 1, 1991, rates shall be used. There shall not be a rate semester for October 1, 1991.

2. Review and adjust the provider's current cost report on file to reflect the results of desk or on-site audits, if available.

3. Determine total allowable cost by reimbursement class for property cost, resident care cost, and operating cost~~, and return on equity or use allowance if applicable.~~ See the Definitions section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A. ~~Costs for providers with six beds or less shall be allocated to each reimbursement class by the methodology shown in Appendix A-1.~~

4. Calculate per diems for each of the ~~four~~ three cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.

~~5. Calculate the target rate of inflation factor representing the allowable increase in operating and resident care costs from the prior cost reporting period. The target rate of inflation factor is calculated by multiplying 1.786 times the simple average of the monthly Florida ICF/MR-DD Cost Inflation Indices associated with the more recent cost reporting period divided by the simple average of the monthly indices associated with the prior cost reporting period.~~

~~6. This step presumes that the cost components of the cost reporting period immediately prior to the current cost report have been adjusted for base year ceiling limitations, inflation target rate limits and incentives, and that they now represent the allowable base costs against which the current costs are to be evaluated. If the current year cost report includes new costs that were incurred in order to meet State or Federal rules, laws, regulations, or licensure and certification standards, and the provider did not request an interim rate adjustment for those costs during that cost reporting period or if the costs did not meet the $5,000 and 1 percent threshold under the interim rate provisions~~

~~in Section IV.G., then an adjustment shall be made to the current base year costs such that the calculation of the target cost appropriately accounts for cost incurred in meeting laws, rules, or regulations. For such an adjustment to be made, the provider must furnish adequate supporting documentation with the cost report. Multiply the adjusted base cost components for operating and resident care costs for each reimbursement class by the target rate factor computed in Step 5 above to reflect the allowable change in costs. See Appendix C.~~

~~7.~~ ~~Compare the operating and resident care cost per diems resulting from Step 6 with the respective per diems from Step 4 for each reimbursement class.~~

~~(a)~~ ~~If the operating per diem for either reimbursement class from Step 4 is less than the respective operating per diem from Step 6, then establish the new operating base per diem as the per diem from Step 4 plus an incentive of one-half of the difference between the two per diems, not to exceed 10 percent of the Step 4 per diem. The operating incentive shall be prorated for the percentage of days that the provider is out of compliance with any Condition of Participation during the rate semester in effect one year prior to the rate semester being set. For example, a provider not out of compliance with a Condition of Participation shall receive 100% of the incentive amount. A provider that is out of compliance for 30 days of a 183 day rate semester shall receive 83.61% of the incentive amount based on 153 days divided by 183 days. If the operating per diem from Step 4 is greater than the Step 6 per diem, then establish the new operating base per diem as the Step 4 per diem, not to exceed the base cost per diem from Step 6 inflated by the target rate factor.~~

~~(b)~~ ~~If the resident care per diem for either reimbursement class from Step 4 is less than the respective resident care per diem from Step 6 then establish the new resident care base per diem as the per diem from~~

~~Step 4 plus an incentive calculated as 50 percent of the difference between the Step 4 per diem and the Step 6 per diem, not to exceed 3 percent of the Step 4 per diem. The resident care incentive shall be prorated for the percentage of days that the provider is out of compliance with any Condition of Participation during the rate semester in effect one year prior to the rate semester being set. For example, a provider not out of compliance with a Condition of Participation shall receive 100% of the incentive amount. A provider that is out of compliance for 30 days of a 183 day rate semester shall receive 83.61% of the incentive amount based on 153 days divided by 183 days. If the resident care per diem from Step 4 is greater than the Step 6 per diem, then establish the new resident care base per diem as the Step 4 per diem, not to exceed the base cost per diem from Step 6 inflated by the target rate factor.~~

~~c)~~ ~~If different operating cost rate components are produced in this rate setting methodology, the total operating rate cost component incentive that is determined shall be allocated to both classes by weighting with patient days of each class. This shall equalize the operating rate cost components and allow for more meaningful trend comparison between cost reporting periods. See Appendix C, for an example.~~

~~8.~~5. The new base per diems for property ~~and return on equity or use allowance~~ shall be the per diems established in step 4 above.

~~9.~~ ~~Rebasing of the operating and resident care component per diems shall occur every five (5) years or whenever fifty percent (50%) of private providers are reimbursed less than reported, allowable costs (whichever occurs first). In detail, rebasing will occur in the rate semester in which fifty percent (50%) or more of the private providers' operating and resident care per diem rates (combined) are less than the operating and resident care inflated costs (combined) (inflated at 1x National DRI as Florida weighted) based upon~~

~~eligible cost reports, or each five (5) years counting from October 1, 1991 (i.e., the first rebasing occurring on October 1, 1996) whichever occurs first. The rebasing calculation methodology shall be identical to that used for the October 1, 1989 rate semester rebasing (Section V.A. 1.-5.) except that rebasing shall occur only for providers whose inflated combined operating and resident care rate does not cover one hundred percent (100%) of their combined operating and resident care inflated costs. Individual providers which would qualify for rebasing based on April 1, 1991 rates, shall be rebased effective July 1, 1991.~~

~~10.~~6. Using the appropriate current ~~base~~ per diem for resident care and operating costs from Step ~~7~~4 above, calculate the prospective operating and resident care per diems for the new rate semester by multiplying each of the base per diems by the fraction:

Simple average of the Florida ICF/MR-DD monthly cost inflation indices for the prospective rate semester divided by the simple average of the Florida ICF/MR-DD monthly cost inflation indices for the cost report period used to calculate current base per diems. For rates effective July 1, 1991, the prospective rate semester used in calculating the above fraction shall be the period July 1, 1991 through March 31, 1992.

~~11.~~7. Establish the total prospective per diem for each reimbursement class as the sum of the appropriate operating and resident care per diems resulting from Step ~~9~~6 plus the current approved per diems for property ~~and return on equity or use allowance, if applicable~~, from Step ~~8~~5.

~~C. Base year ceilings for new providers in facilities with six beds or less:~~

~~1. Property costs per diems shall not be in excess of the ceiling limitations established in Section III. of this plan.~~

~~2. Operating costs per diems shall not be in excess of the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that~~

~~have prospective rates. This ceiling shall be recalculated for every rate semester beginning April 1 and October 1 of each year.~~

~~3. Resident care costs per diems shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate. The ceiling shall be recalculated for every rate semester beginning April 1 and October 1 of each year.~~

~~4. Total costs per diem ceilings (including return on equity):~~

~~Shall not exceed the total costs per diem ceilings for interim cost per diems in section IV.H.2.D. multiplied times 1.04. When a provider is limited to the total ceiling in the base year, the total ceiling shall be allocated to each component to cost settle interim rates and to calculate prospective rates based on the percentage that each component's actual allowable cost is to the total actual allowable cost for all components, including return on equity, in the base year.~~

~~Example:~~	~~Interim Cost~~	~~Percent to total~~	~~Ceiling~~
~~Operating~~	~~46.52~~	~~23.26~~	~~43.73~~
~~Resident Care~~	~~127.11~~	~~63.56~~	~~119.48~~
~~Property~~	~~20.56~~	~~10.28~~	~~19.33~~
~~ROE~~	~~5.81~~	~~2.9~~	~~5.46~~
~~Total~~	~~200~~	~~100%~~	~~188~~

VI. Payment Assurance

The state shall pay each provider for services provided in accordance with the requirements of the Florida Title XIX state plan and applicable state or federal rules and regulations. The payment amount shall be determined for each provider according to the standards and methods set forth in this Florida Title XIX ICF/MR-DD Reimbursement Plan for Publicly Owned and Publicly Operated Facilities.

IX. Definitions

Acceptable Cost Report: A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

AHCA: Agency for Health Care Administration, also known as the agency.

HCFA PUB.15-1: also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Health Care Financing Administration.

~~HRS~~DCF: Department of ~~Health and Rehabilitative~~ Children and Family Services~~, also known as the Department.~~

ICF/MR-DD Operating Costs: Those costs not directly related to resident care or property costs. Operating costs include administrative, plant operation, laundry and housekeeping costs. ~~Return on equity or use allowance costs are not included in operating costs.~~

ICF/MR-DD Resident Care Costs: Those costs directly attributed to nursing services, dietary costs, and other costs directly related to resident care such as activity costs, social services, and all medically-ordered therapies.

ICF/MR-DD Property Costs: Those costs related to the ownership or leasing of an ICF/MR-DD. Such costs may include property taxes, insurance, interest and depreciation, or rent.

~~ICF/MR-DD Return on Equity or Use Allowance Costs: See Sections III.H. and III.I. of this plan.~~

Title XVIII: Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395pp).

Title XIX: Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396i)

Medicaid Interim Reimbursement Rate: A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.

APPENDIX A

Provider Number

Provider Name

Address

FY: 09/30/84

Audit Status Unaudited

		COL A Resid./ Inst.	COL B Non-amb./ Medical	COL C TOTAL
A.	Alloc of Exp (Excl B&C)			
1.	Resident Days	02461	8325	10786
2.	OPER. EXPENSE COMP			
a.	Administration	-	-	120482
b.	Plant Operation	-	-	45060
c.	Laundry	-	-	15265
d.	Housekeeping	-	-	29090
e.	Oper. Exp. Comp and Per Diem	19.460	19.460	209897
3.	Resident Care Expense			
a.	Dietary	-	-	74861
b.	Other -	-	34188	
c.	Nursing	-	-	86018
d.	Res. Care Exp. and Per Diem	18.0852	18.0852	19.5067
4.	PROP. EXP. COMP. AND PER DIEM	8.605	8.605	92812
5.	ROE/UA COMP & PER DIEM	6.604	6.604	71236
B.	DIRECT CARE EXPENSE			
1.	Staffing	.5	1.	-
2.	Total Staffing Required	1230.5	8325	95555
3.	Staffing Percent	12.877%	87.123	100%
4.	Alloc. of Direct Care	39263.97	26542.03	304906
5.	Dir. Care Exp. Per Diem	15.945	31.9090	
C.	ADDITIONAL SERVICES EXPENSE			
1.	Medicaid Patient Days	2461	8275	10736
2.	Add. Ser. (Sch.AM-6)	36780	69380	106160
3.	Add. Ser. Exp. Per Diem	14.951	8.3839	
D.	MEDICAID PER DIEM COST			
1.	Operating Component	19.460	19.460	209897
2.	Resident Care Component	48.985	58.378	606133
3.	Property Cost Component	8.605	8.605	92812
	Subtotal (Schedule BM)	.-	.-	-
4.	ROE/USE ALLOW Comp.	6.604	6.604	71236
5.	TOTAL PER DIEM COST	83.654	93.047	980078